CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155203	B. WING			10/31/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	8			ARKS AVE		
HILLCRE	ST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0000							
	A Life Safety Co	ode Recertification and	KO	0000	Submission of this plan of		
	State Licensure S	Survey was conducted by			correction does not constitute admission or agreement by t		
	the Indiana State	Department of Health in			provider of the truth of facts	ile	
	accordance with	42 CFR 483.70(a).			alleged or correction set forth	n on	
					the statement of deficiencies		
	Survey Date: 10	0/31/11			This plan of correction is		
		· - · · -			prepared and submitted beca		
	Facility Number:	. 000110			of requirement under state a federal law.	nd	
	Provider Number				Please accept this plan of		
	AIM Number: 1				correction as our credible		
	Alivi Number. 1	1002/1120			allegation of compliance. Th	is	
					plan of correction will be		
	-	Bugni, Life Safety Code			completed on or before		
	Specialist				November 30 th , 2011.		
	At this Life Safe	ty Code survey, Hillcrest					
	Centre for Health	h and Rehabilitation was					
	found not in com	npliance with					
		r Participation in					
	•	aid, 42 CFR Subpart					
		Safety from Fire and the					
	2000 edition of t						
		ciation (NFPA) 101, Life					
		C), Chapter 19, Existing					
	- '	-					
	16.2.	rupancies and 410 IAC					
	10.2.						
	Hillcrest Centre	for Health and					
	Rehabilitation is	a two story building with					
		basement constructed at					
	•	nes. The original building					
		6 and constructed with					
		on consisting of a two					
	imacu constructi	on consisting of a two					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	ì	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JL9C21

Facility ID:

000110

If continuation sheet

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 02	COMPL	
11112 12111	or conduction	155203		LDING		10/31/2	
			B. WIN		DDDESS CITY STATE 7ID CODE		• • • • • • • • • • • • • • • • • • • •
NAME OF I	PROVIDER OR SUPPLIER	ŧ			ARKS AVE		
HILLCRE	EST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n thick concrete decks					
		floor, one hour fire rated					
		alls, two fire barrier walls					
		vo hour construction on					
	•	exterior walls with metal					
		lf hour rated drywall, a					
	mix of concrete a	and metal stud interior					
	walls with one ha	alf hour rated drywall,					
	and metal trusses	s and wooden rafters in					
	the roof assembly	y. Based on the lowest					
	construction type	e, the facility construction					
	type was classific	ed as Type V (111)					
	construction. Th	ne original building was					
	built with an ope	en column foundation					
	exposed at the er	ntire south length of the					
	facility. In 1974	, a two story addition					
	including the lev	rel 1 Transcare Unit and					
	level 2 East Win	g was constructed to the					
		original building and the					
	column foundation	on was converted into a					
	poured finished p	partial basement for					
		and is also of Type V					
		on. Because the original					
		addition are the same					
		tion, the facility was					
	surveyed as one						
	J = 1. 2.2 2.2.4	5					
	The facility is fu	lly sprinklered. The					
	_	alarm system with					
		on all levels including					
		I spaces open to the					
		acility has a capacity of					
		ensus of 77 at the time of					
		nisus of // at the tillie of					
	this survey.						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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If continuation sheet

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PRINTED: FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 BUILDING 155203 10/31/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION ROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 11/04/11. The facility was found not in compliance with the aforementioned regulatory requirement as evidenced by the following: K0018 Doors protecting corridor openings in other than required enclosures of vertical openings, SS=E exits, or hazardous areas are substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Roller latches are prohibited by CMS regulations in all health care facilities. K0018 K018 Require that a facility has: 11/30/2011 Based on observation and interview, the Doors protecting corridor facility failed to ensure 5 of 163 corridor openings in other than required doors would latch and resist the passage enclosures of vertical openings, of smoke with no impediment to closing exits, or hazardous areas are substantial doors, such as those the doors. This deficient practice affects constructed of 1% inch any residents using the first floor beauty solid-bonded core wood, or shop in the Service Hall where the capable of resisting fire for at mechanical room is located, 2 residents least 20 minutes. Doors in who reside in room 149, 2 residents in sprinklered buildings are only required to resist the passage of room 319, and any resident using the main smoke. There is no impediment dining room located adjacent to the to the closing of the doors. Doors kitchen. are provided with a means suitable for keeping the door closed. Dutch doors meeting Findings include: 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by

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JL9C21

Facility ID:

000110

If continuation sheet

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11/22/2011

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MU	JLTIPLE CON	NSTRUCTION	(X3) DATE S COMPL		
AND PLAIN	OF CORRECTION	155203	A. BUIL		02	10/31/20	
		100200	B. WINC		DDDDGG CVTV CTATE TID CODE	10/01/20	311
NAME OF P	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HILLCRE	ST CENTRE FOR I	HEALTH AND REHABILITATION			SONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
		ations on 10/31/11 during			CMS regulations in all health care facilities. The facility will		
		lity from 8:00 a.m. to			ensure this requirement is me		
	1:10 p.m. with th				through the following: 1. No		
	_	dministrator, the room			residents were harmed. The		
		floor Service Hall			doors in the Service Hall	.om	
		n, resident room 149,			mechanical room, resident ro 149 and 319, and the main d		
		9, and the kitchen each			room doors located adjacent		
		ap along the top and			the kitchen have all been rep	aired	
	~	the doors. Furthermore,			of 1 inch gaps. Additionally,		
		or 149 failed to latch into			149 door latch was repaired.All residents have the potenti		
	the door frame.	This was verified by the			be affected. Facility inspecte		
	maintenance sup	ervisor and administrator			ensure no further areas of		
	at the time of obs	servations.			concern. 3. Maintenance sta	ff	
					in-serviced on K018. 4. The	.	
	3.1-19(b)				Administrator or designee wil utilize the Interior Preventativ		
					Maintenance Monitoring Too		
					monthly times 3 months and		
					Quarterly until compliance ha	ıs	
					been maintained for 2		
					consecutive quarters (See Attachment A). The audits wi	ll be	
					reviewed during the facilities		
					quality assurance meeting ar		
					issues Will be addressed and	the	
					above plan will be altered accordingly, if needed. 5. The	_	
					above plan of correction will l		
					completed on or before		
					November 30, 2011.		
K0020		or shafts, light and ventilation					
SS=E		d other vertical openings e enclosed with construction					
		tance rating of at least one					
	_	nay be used in accordance					
		.3.1.1.				.	
		ation and interview, the	K0	020	K 020 Requires that a facility		11/30/2011
	facility failed to	ensure 1 of 4 vertical			Stairways, elevator shafts, ligand ventilation shafts, chutes		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 BUILDING 155203 10/31/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE and other vertical openings openings was enclosed with construction between floors are enclosed with having at least a one hour fire resistance. construction having a fire LSC 19.3.1.1 requires any vertical resistance rating of at least one opening to be enclosed or protected in hour. The facility will ensure this requirement is met through the accordance with LSC 8.2.5. LSC 8.2.5.4 following: 1. No residents were refers to 7.1.3.2.1 for enclosure of exits. harmed. A self-closing latch was LSC 7.1.3.2.1 requires openings in the installed to the 1 West stairway separation be protected by fire door door. 2. All residents have the assemblies equipped with door closers potential to be affected. Facility inspected to ensure no further complying with 7.2.1.8. NFPA 80, the areas of concern. 3. Standard for Fire Doors and Fire Maintenance staff in-serviced on Windows at 2-1.2 requires fire door K020. 4. The Administrator or assemblies to include latches. NFPA 80, designee will utilize the Interior Preventative Maintenance 2-1.4 requires fire doors to be closed and Monitoring Tool monthly times 3 latched at the time of fire. This deficient months and then Quarterly until practice could affect 34 residents who compliance has been maintained for 2 consecutive quarters (See reside on the second floor and could use Attachment A). The audits will be the 1 West Hall stairway door during an reviewed during the facilities evacuation. quality assurance meeting and issues Will be addressed and the Findings include: above plan will be altered accordingly, if needed. 5. The above plan of correction will be Based on observation on 10/31/11 at 8:30 completed on or before a.m. with the maintenance supervisor and November 30, 2011. administrator, the 1 West stairway door leading to the second floor was not provided with latching hardware to allow the door to latch and close in the door frame. This was verified by the maintenance supervisor and administrator at the time of observation. 3.1-19(b)

000110

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION 02	(X3) DATE : COMPL		
		155203	A. BUII B. WIN			10/31/2	011
		l .	D. WIIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ARKS AVE		
		HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
K0025 SS=E	least a one half ho accordance with 8 terminate at an atr protected by fire-raglass panels and s two separate compeach floor. Dampe penetrations of sm heating, ventilating systems. 19.3.7 19.1.6.4 1. Based on obset the facility failed smoke barriers w provide at least a resistance rating. affects 45 resider floor. Findings include: Based on observa maintenance support on 10/31/11 during attic smoke barrier 12:40 p.m., the fobarrier walls about had penetrations expandable foam a. The 1 West H had sixteen, one affrest opped with insulation. b. The 1 East Hamiltonia to the facility failed strength of the facility failed smoke barrier walls about the fa	ations with the ervisor and administrator ng observation of the ers from 11:10 a.m. to ollowing attic smoke ve smoke barrier doors fire stopped with unrated	K	0025	K 025 Requires that a facility has: Smoke barriers are construct to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazin by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not requir duct penetrations of smoke barrie fully ducted heating, ventilating, and air conditioning systems. The facility will ensure this requirement is met through th following: 1. No residents were harmed areas identified as a concern were replaced with rated, expandable foam	g or ed in rs in ne	11/30/2011
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID: J	_9C21	Facility II	D: 000110 If continuation sl	neet Pac	ge 6 of 40

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	A. BUII		O2	(X3) DATE COMPL 10/31/2	ETED
NAME OF F	ST CENTRE FOR SUMMARY S' (EACH DEFICIEN REGULATORY OR firestopped with insulation.	HEALTH AND REHABILITATION FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) unrated expandable foam	A. BUII B. WIN	G STREET AI	DDRESS, CITY, STATE, ZIP CODE RKS AVE SONVILLE, IN47130 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) installation including: a. The 16 areas of the 1 Wes Hall smoke barrier wall.	10/31/2	
	c. The first floor station smoke bath one inch to four with unrated explicitly described barrier by room one inch to four with unrated explicitly based on an intermaintenance sup 12:40 p.m., the first were firestopped foam insulation. administrator at the conference on 10:3.1-19(b) 2. Based on obsetthe facility failed wall smoke barriethrough all concerniterstitial spaces.	ervisor on 10/31/11 at irst floor smoke barriers with unrated expandable. This was verified by the he 1:00 p.m. exit			b. The 21 areas of the 1 Easi smoke barrier wall. c. The 26 areas of the first flot Transcare Hall nurses' statio smoke barrier wall. d. The 25 areas of the first flot Transcare Hall smoke barrier room 125. A rated, expandable foam waused to create a continuous smoke barrier for the first flot respiratory office east wall are the west wall of resident room 314. 2. All residents have the pote to be affected. Facility inspet to ensure no further areas of concern. 3. Maintenance staff in-servicion K025. 4. The Administrator or designal utilize the Interior Prevent Maintenance Monitoring Too monthly times 3 months and Quarterly until compliance has been maintated for 2 consecutive quarters (Sentenance A).	oor n oor r by as or nd ential cted gnee tative I then sined see	
	outside wall, from from a smoke ba a combination th be continuous the spaces, such as the ceiling, including	an outside wall to an m a floor to a floor, or rrier to a smoke barrier or ereof. Such barriers shall rough all concealed nose found above a g interstitial spaces. This e could affect 2 residents			The audits will be reviewed of the facilities quality assurance meeting and issues will be addressed and the ab plan will be altered according needed. 5. The above plan of correcti will be completed on or befor November 30, 2011.	ee ove gly, if on	

Facility ID:

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		oz 02	(X3) DATE S COMPL	ETED
		155203	B. WING			10/31/20	011
	ROVIDER OR SUPPLIER	HEALTH AND REHABILITATION	2	203 SPAF	DRESS, CITY, STATE, ZIP CODE RKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID EFIX CAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
		om 314 and any resident cory therapy office.					
	Findings include:						
	during a tour of to 1:10 p.m. on 1 respiratory therapthree inch by three missing exposing between. Addition west wall had a farea of drywall mestuds and the spa	he facility from 8:00 a.m. 0/31/11, the first floor by office east wall had a see inch area of drywall at the steel studs and space onally, resident room 314 four inch by four inch missing exposing the steel ce between. This was aintenance supervisor					
K0027 SS=E	a 20-minute fire pr least 1¾-inch thick Non-rated protective 48 inches from the permitted. Horizor with 7.2.1.14. Doc automatic closing in 19.2.2.2.6. Swinging to swing with egree not required. 19 Based on observation	smoke barriers have at least otection rating or are at a solid bonded wood core. We plates that do not exceed bottom of the door are not sliding doors comply ors are self-closing or in accordance with ing doors are not required as and positive latching is .3.7.5, 19.3.7.6, 19.3.7.7 action and interview, the ensure 1 of 7 sets of ors would restrict the	K002	27	K 027 Requires that a facility has: Door openings in smoke barr	iers	11/30/2011

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203		LDING	NSTRUCTION 02	(X3) DATE COMPI 10/31/2	LETED
	PROVIDER OR SUPPLIEF	HEALTH AND REHABILITATION	•	203 SPA	DDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN47130		
	SUMMARY S (EACH DEFICIEN REGULATORY OR movement of sm minutes. LSC, S doors in smoke b LSC, Section 8.3 requires doors in the opening leav clearance necess which is defined movement of sm practice could af reside on the sec Findings include Based on observ maintenance sup on 10/31/11 at 1 floor West Hall s near the nurses' s completely, leav between the door the maintenance administrator at second	HEALTH AND REHABILITATION TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION) Toke for at least 20 Section 19.3.7.6 requires coarriers shall comply with 3.4. LSC, Section 8.3.4.1 It smoke barriers to close ing only the minimum ary for proper operation as 1/8 inch to restrict the toke. This deficient feet 15 residents who cond floor West Hall. This was the second set of smoke barrier doors station did not close ing a two inch gap rs. This was verified by		G STREET A 203 SPA	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) have at least a 20-minute fire protection rationare at least 1%-inch thick solid bonded we core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door apermitted. Horizontal sliding doors committed. Horizontal sliding doors committed. Horizontal sliding doors committed. Horizontal sliding doors committed. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with equand positive latching is not required. 19.3 19.3.7.6, The facility will ensure this requirement is met through the following: 1. No residents were harmed the second floor, West Hall smoke barrier door was corrected. 2. All residents have the pote to be affected. Facility inspections.	ng or vood are aply gress 3.7.5, the d. rn on	(X5) COMPLETION DATE
	3.1-19(b)				to ensure no further areas of concern. 3. Maintenance staff in-serv on K027. 4. The facility Fire Drill chec sheet was updated to include the inspection of the doors for gaps at the time of facility monthly fire drill (See attachment B). 5. The Administrator or desi will review the monthly Fire I	fire the	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: JL	9C21	Facility I	D: 000110 If continuation s	sheet Pa	ge 9 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			(X2) MU A. BUIL B. WING	DING	NSTRUCTION 02	(X3) DATE COMPL 10/31/2	ETED
	ROVIDER OR SUPPLIER	HEALTH AND REHABILITATION	B. WINC	STREET AI	DDRESS, CITY, STATE, ZIP CODE RKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0029 SS=E	fire-rated doors) or extinguishing system	d construction (with ¾ hour ran approved automatic fire em in accordance with 8.4.1 otects hazardous areas.			Report each month to ensure compli is being maintained. 6. The above plan of correct will be completed on or befor November 30, 2011.	ion	
	extinguishing systemate separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1 Based on observational facility failed to do 17 hazard combustible storated feet in size, were closing devices with doors to automate the door frames. could affect 12 residence from the second floor doors to a feet in size, were closing devices with the door frames. Could affect 12 residence floor doors to automate the second floor doors to a feet in size, were closing devices with the door frames. Could affect 12 residence floor doors to automate the second floor doors	em option is used, the areas of other spaces by smoke and doors. Doors are on-rated or field-applied that do not exceed 48 inches of the door are permitted. Attion and interview, the ensure the corridor doors out areas, such as a tage rooms over 50 square provided with self which would cause the ically close and latch into This deficient practice esidents who reside on 400 Hall.	K0	029	K 029 Requires that a facility has: One hour fire rated construct (with ¾ hour fire-rated doors) or an approvautomatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resist partitions and doors. Doors are self-closing non-rated or field-applied protective plates	ved ting and	11/30/2011
	-	e maintenance dministrator, the corridor floor housekeeping			do not exceed 48 inches from the bottom of door are permitted. 19.3.2.1	the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MI A. BUII		NSTRUCTION 02	(X3) DATE S	ETED	
		155203	B. WIN			10/31/2	011
	ROVIDER OR SUPPLIER	HEALTH AND REHABILITATION		203 SPA	DDRESS, CITY, STATE, ZIP CODE NRKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	room 412, the set the basement stormeasured from of square feet to one feet and stored can supplies, paper to shelves, each lace This was verified	om 112, the second floor cond floor room 201, and rage room which each ne hundred seventeen e hundred eighty square ardboard boxes of paper owels, and wooden ked a self closing device. If by the maintenance diministrator at the time of			The facility will ensure this requirement is met through the following: 1. No residents were harmed Self-closing devices were installed on the corridor doors that were iden as a concern including; the fifloor house-keeping closet next to room the second floor housekeeping closet next to 412, the second floor room 201, at the basement storage room. 2. All residents have the pote to be affected. Facility inspet to ensure No further areas of concern. 3. Maintenance in-serviced of K029. 4. The Administrator or designal utilize the Interior Prevent Maintenance Monitoring Toomonthly times 3 months and Quarterly until compliance has been maintated for 2 consecutive quarters (South Attachment A). The audits will be reviewed of the facilities quality assurance meeting and issues will be addressed and the abplan will be altered according needed. 5. The above plan of corrective will be completed on or before November 30, 2011.	tified rst 112, ng nd ential cted in gnee tative I then ined ee luring e ove gly, if	
K0038 SS=E		nged so that exits are at all times in accordance 19.2.1					

000110

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		155203	B. WIN			10/31/2011	
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	3			ARKS AVE		
HILLCRE	EST CENTRE FOR	HEALTH AND REHABILITATION	l		RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	1. Based on obs	ervation and interview,	K	0038	K 038	11/30/2011	
	the facility failed	d to ensure 5 of 6 exit			Requires that a facility has:		
	1	d with delayed egress			Exit access is arranged so the	hat	
		ided with a sign indicating			exits are readily		
	_	LARM SOUNDS DOOR			accessible at all times in accordance with section		
					7.1. 19.2.1		
		ED IN 15 SECONDS.			The facility will ensure this		
	_	es approved, listed,			requirement is met through t	the	
		ocks shall be permitted to			following:		
	be installed on d	oors serving low and			1. No residents were harmed		
	ordinary hazard	contents in buildings			Signs that read "Push Until / Sounds	Alarm	
	protected throug	hout by an approved,			Door Can Be Opened in 15		
	supervised autor	natic fire detection system			Seconds" was installed on d	loors	
	in accordance w	ith Section 9.6, or an			identified as		
		vised automatic sprinkler			a concern. This includes; th		
		lance with Section 9.7,			floor service hall exit, the two	0	
		itted in Chapters 12			Administration		
	_	rided the following			Hall front exits, and the two Administration Hall side exit	e	
		· ·			Codes to the second floor	3.	
		(a) The doors shall			stairway exits will be posted	on	
	_	uation of an approved,			the 3 doors identified as a		
	_	natic sprinkler system in			concern, which include; the		
		Section 9.7 or upon the			2 East stairway door, the 2 \		
	actuation of any				Stairway door, and the 2 So stairway doors.	utri	
	activation of not	more than two smoke			2. All residents have the pot	ential	
	detectors of an a	pproved, supervised			to be affected. Facility insp		
	automatic fire de	etection system in			to ensure no		
	accordance with	Section 9.6. (b) The			other areas of concern.		
		ck upon loss of power			3. Maintenance staff in-servi	iced	
	controlling the lo	• •			on K038.	ignoo	
		An irreversible process			 The Administrator or des will utilize the Interior Prever 	•	
		lock within 15 seconds			Maintenance Monitoring Too		
		of a force to the release			monthly times 3 months and		
					Quarterly until		
	-	in 7.2.1.5.4 that shall not			compliance has been mainta		
	_	sceed 15 lbf nor be			for 2 consecutive quarters (S	See	
	required to be co	ontinuously applied for			Attachment A).		
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event ID:	L9C21	Facility 1	ID: 000110 If continuation s	sheet Page 12 of 40	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	ONSTRUCTION 02	(X3) DATE COMPL		
		155203	B. WIN			10/31/2	011
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ARKS AVE		
HILLCRE	EST CENTRE FOR	HEALTH AND REHABILITATION		JEFFEF	RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
TAG	†	onds. The initiation of the		TAG	The audits will be reviewed	durina	DATE
		hall activate an audible			the facilities quality assurance	•	
	_	nity of the door. Once			meeting and issues		
	_	s been released by the			will be addressed and the ab plan will be altered according		
		rce to the releasing			needed.	giy, ii	
	* *	g shall be by manual			5. The above plan of correct		
	means only.	0 - 0,			will be completed on or befo	re	
		re approved by the			November 30, 2011.		
	_	jurisdiction, a delay no					
		conds shall be permitted.					
	_	adjacent to the releasing					
	device, there sha	all be a readily visible,					
	durable sign in le	etters not less than 1 inch					
	high and not less	s than 1/8 inch in stroke					
	width on a contr	asting background that					
	reads as follows:	PUSH UNTIL ALARM					
	SOUNDS DOO	R CAN BE OPENED IN					
	15 SECONDS.	This deficient practice					
	affects all reside	nts in the facility.					
	Findings include	y:					
		ations on 10/31/11 during					
		lity with the maintenance					
	-	dministrator from 8:00					
	_	the first floor Service					
		o Administration Hall					
	•	he two Administration					
		rere each equipped with					
		ocks which unlocked the					
	_	own device after pressure					
		ten seconds to the door					
	_	re. Furthermore, the five					
	exit doors were	not provided with a sign					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			LDING	NSTRUCTION 02	(X3) DATE : COMPL 10/31/2	ETED	
NAME OF I	DROVIDED OF GUIDN 155		J. 17111		DDRESS, CITY, STATE, ZIP CODE		
	PROVIDER OR SUPPLIER				ARKS AVE		
HILLCRE	ST CENTRE FOR	HEALTH AND REHABILITATION		JEFFER	RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
TAG		UNTIL ALARM		IAG	,		DATE
		R CAN BE OPENED IN					
		This was verified by the					
		ervisor and administrator					
	at the time of obs						
	3.1-19(b)						
		ervation and interview,					
		I to ensure 3 of 3 second					
	floor stairway ex	-					
		times. LSC 7.2.1.5.1					
	-	nall be arranged to be rom the egress side					
		ilding is occupied.					
		ed, shall not require the					
		ool, or special knowledge					
	1	ration from the egress					
	•	ent practice affects 34					
		side on the second floor					
		ne 2 East, 2 West and 2					
		xits during an evacuation.					
	Findings include	:					
	Događ om obga	ations on 10/21/11 during					
		ations on 10/31/11 during lity from 8:00 a.m. to					
	1:10 p.m. with the	_					
	•	dministrator, the second					
	_	way exit, 2 West stairway					
		stairway exit were each					
		push button coded door					
	1 -	an interview with the					
	maintenance sup	ervisor on 10/31/11 at					

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	(X2) MUL' A. BUILDI B. WING		02	(X3) DATE (COMPL 10/31/20	ETED
	PROVIDER OR SUPPLIER	L HEALTH AND REHABILITATION	2	203 SPA	DDRESS, CITY, STATE, ZIP CODE RKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	South stairway e combinations are Staff are the only door locking com on 10/31/11 at 1: alarm system wa West, and 2 South not unlock to ope system was active and 2 south stair combinations on acknowledged by 1:10 p.m. exit combinations on acknowledged by 1:10	enot given to residents. To people who know the abination. Furthermore, 00 p.m., when the fire is tested, the 2 East, 2 is the stairway exit doors did en when the fire alarm ated. The 2 East, 2 West, way exit door locking by know by staff was by the administrator at the inference on 10/31/11 The entry of the entr					

	OF OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION 02	(X3) DATE COMPL	
MINDIEMIN	or conduction	155203	A. BUII			10/31/2	
		100200	B. WIN		DDDEGG CHTW CTATE TID CODE	10/01/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
HILLCRE	EST CENTRE FOR I	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	*	ff can readily unlock such					
		s. This deficient practice					
		nts who reside on the					
		would use the 2 East, 2					
		h stairway exits during an					
	evacuation.						
	Findings include	:					
		ations on 10/31/11 during					
	a tour of the facil	lity from 8:00 a.m. to					
	1:10 p.m. with th	ne maintenance					
	supervisor and ac	dministrator, the second					
	floor 2 East stair	way exit, 2 West stairway					
	exit, and 2 South	stairway exit were each					
	provided with a p	oush button coded door					
	lock. Based on a	n interview with the					
	maintenance sup	ervisor and administrator					
	on 10/31/11 at 12	2:45 p.m., the 2 East, 2					
	West and 2 South	h stairway exit door lock					
	combinations are	e not given to residents					
	and staff are the	only people who know					
	the door locking	combination and there					
	are no residents v	who reside on the second					
	floor 2 East, 2 W	est and 2 South Halls					
	with a clinical di	agnosis to be in a secure					
	building. Further	rmore, on 10/31/11 at					
	1:00 p.m., the fir	e alarm system was					
	tested and the 2 I	East, 2 West, and 2 South					
	stairway exit doo	ors were not electrically					
	wired to open wh	nen the fire alarm system					
	was activated. T	The 2 East, 2 West, and 2					
	south stairway ex	xit door locking					
	combinations on	ly know by staff was	L				

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Event ID:

JL9C21

Facility ID:

000110

If continuation sheet

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155203	B. WIN			10/31/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	FROVIDER OR SUFFLIER				ARKS AVE		
HILLCRE	EST CENTRE FOR	HEALTH AND REHABILITATION		JEFFEF	RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)		IAG	DLI ICILICI I		DATE
		y the administrator at the				ļ	
	1.10 p.m. exit co	inference on 10/31/11.					
	3.1-19(b)						
K0045 SS=E	discharge, is arrar single lighting fixtu area in darkness. emergency lighting	ans of egress, including exit nged so that failure of any ure (bulb) will not leave the (This does not refer to g in accordance with section					
	facility failed to of 10 exit means so the failure of a (bulb) would not darkness. This d affect any reside	ation and interview, the ensure the lighting for 1 of egress was arranged any single lighting fixture leave the area in deficient practice could nts, as well as staff, and a basement physical	K	0045	K 045 Requires that a facility has: Illumination of means of egree including exit discharge, is arranged so the failure of any single lighting fixture (bulb) will not the area in darkness. (This does not reference emergency lighting in accordance with section 7.8.) 19.2.8 The facility will ensure this requirement is met through the following:	at leave er to	11/30/2011
	10 p.m. with the and administrato west exit was equal fixture with only interview at the tamaintenance sup	maintenance supervisor r, the physical therapy uipped with a dual light one bulb. Based on time of observation, the ervisor acknowledged the al therapy west exit dual one bulb.			1. No residents were harmed The light fixture identified as area of concern was equipped with 2 bulbs. 2. All residents have the pote to be affected. Facility inspet to ensure no other areas of concern. 3. Maintenance staff in-servi on K045. 4. The Administrator or desi will utilize the Interior Prever.	an 2 light ential ected ced gnee	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155203		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 02	(X3) DATE SURVEY COMPLETED 10/31/2011	
	PROVIDER OR SUPPLIER	HEALTH AND REHABILITATION	STREET A	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN47130	1
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
K0048 SS=F	patients and for the of an emergency. Based on record of facility failed to it class portable firm written plan for the residents in the electron of the care occupancy of provide for the fact of the	review and interview, the include the kitchen K extinguisher in the he protection of 77 of 77 event of an emergency. uires a written health fire safety plan that shall following: of alarm to the fire alarms re f immediate area f smoke compartment f floors and building for	K0048	Maintenance Monitoring Too monthly times 3 months and Quarterly until compliance has been mainta for 2 consecutive quarters (\$ Attachment A). The audits will be reviewed of the facilities quality assurance meeting and issues will be addressed and the at plan will be altered according needed. 5. The above plan of correct will be completed on or befo November 30, 2011. K 048 Requires that a facility has: There is a written plan for th protection of all patients and for their evacua in the event of an emergency. 19.7.1.1 The facility will ensure this requirement is met through t following: 1. No residents were harmed The facility Fire Plan (Attach C) was reviewed and amended include types of fire extinguis and their usage. Additionally, the statement w added under the K extinguis "In the event of a fire in the kitchen, staff should first use hood fire suppression system and the K Fire Extinguisher should only be utilized as a secondary	then ained see during se sove gly, if ion re 11/30/2011 e tion he d. ment to shers vas her,

Facility ID:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			(X2) MULTIP A. BUILDING		TRUCTION 02	(X3) DATE S COMPLI 10/31/20	ETED
NAME OF P	PROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE	. 5. 5 1, 2	
HILLCRE	ST CENTRE FOR I	HEALTH AND REHABILITATION	JE	FFERS	ONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
V.0050	Fire Disaster Plan p.m. with the ma administrator, the not address the u extinguisher loca relationship with overhead extingu verified by the ad record review. 3.1-19(b)	w of the facility's written on 10/31/11 at 12:20 intenance supervisor and a Fire Disaster Plan did se of the K class fire ted in the kitchen in the use of the kitchen ishing system. This was liministrator at the time of			means". 2. All residents have the pote to be affected. 3. Facility staff in-serviced or before November 30, 2011. 4. The Administrator or design will utilize the Interior Prevent Maintenance Monitoring Tool monthly times 3 months and a Quarterly until compliance has been maintain for 2 consecutive quarters (Seattachment A). The audits will be reviewed done the facilities quality assurance meeting and issues will be addressed and the about plan will be altered according needed. 5. The above plan of correction will be completed on or before November 30, 2011.	n or gnee tative then ined ee uring e ove ly, if	
K0050 SS=F	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent persone exercise leadershi conducted betwee announcement manualible alarms. Based on intervie facility failed to drills on each shi This deficient pra	s who are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2 ew and record review, the conduct quarterly fire ft for 2 of 4 quarters. actice affects all facility including staff,	K0050		K 050 Requires that a facility has: Fire drills are held at unexpectimes under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of establish		11/30/2011

000110

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MU A. BUILI		NSTRUCTION 02	(X3) DATE SURVEY COMPLETED	
		155203	B. WING	·		10/31/2011
	ROVIDER OR SUPPLIER	HEALTH AND REHABILITATION		203 SPA	DDRESS, CITY, STATE, ZIP CODE RKS AVE SONVILLE, IN47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	with the maintent administrator on fire drill was not second and third of 2011 or for the of the fourth quark Additionally, bas maintenance supduring the review Reports, there was documentation as	of Fire Drill Reports ance supervisor and 10/31/11 at 12:45 p.m., a documented for the shifts of the third quarter e first shift and third shift rter of 2010. sed on interview with the ervisor and administrator of the Fire Drill			routine. Responsibility for planning ar conducting drills is assigned only to competent persons who are qualified to exercise leadersh Where drills are conducted between 9 PM and AM a coded announcement may be used instead of audible alarms. 19.7.1.2 The facility will ensure this requirement is met through the following: 1. No residents were harmed Fire Drill was conducted (See Attachment D). 2. All residents have the pote to be affected. 3. The Maintenance Director designee will utilize the Fire E "Tentative" Schedule planning form to plan monthly fire drills (See Attachment E). 4. Maintenance staff in-service on K050. 5. The Administrator or designing will review the monthly Fire D Report each month to ensure complicing being maintained. The more review will be on-going (See Attachment B). 6. The above plan of correctively will be completed on or before November 30, 2011.	nip. d 6 ne l. e ential or Drill g s ced gnee Drill fance inthly ment ion

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			A. BUILDING 02			COMPL	X3) DATE SURVEY COMPLETED 10/31/2011	
HILLCRE		HEALTH AND REHABILITATION		203 SPA	ADDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN47130			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
K0051 SS=C	according to NFPA Code, to provide eany part of the bui complete fire alarm alarm initiation, au extinguishing system patient sleeping provided that man 200 feet of nurse's located in the path written records of reliable second so Fire alarm system accordance with N maintenance are k is remote annuncia system to an appropriate to an appropriate facility failed to a systems was mai with the application 72, National Fire 7-3.2 requires test in accordance with Chapter 7 or more authority having shall apply. Tab Frequencies' requestions, and initiatested at least ampractice could aff and visitors.	ces or equipment is installed A 72, National Fire Alarm effective warning of fire in Iding. Activation of the m system is by manual fire atomatic detection or em operation. Pull stations areas may be omitted ual pull stations are within a stations. Pull stations are of egress. Electronic or tests are available. A surce of power is provided. If PA 72 and records of a sept readily available. There ation of the fire alarm oved central station. Teview and interview, the ensure 1 of 1 fire alarm nationed in accordance of requirements of NFPA A Alarm Code. NFPA 72, sting shall be performed the schedules in the often if required by the jurisdiction. Table 7-3.2 Ile 7-3.2 "Testing uires alarm initiating of tification appliances, tiating devices to be mually. This deficient fect all residents, staff		0051	K 051 Requires that a facility has: A fire alarm system with approximate components, devices or equipment is instate according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in an part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operating pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations located in the	alled n y e on. e	11/30/2011	
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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			LDING	NSTRUCTION 02	(X3) DATE COMPL 10/31/2	ETED
	PROVIDER OR SUPPLIER	L : HEALTH AND REHABILITATION	•	STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE RSONVILLE, IN47130		
	SUMMARY S' (EACH DEFICIEN REGULATORY OR Findings include Based on review Fire Alarm Syste Reports Quarterl p.m., the quarterl service date of 0' of the report. Th report showed th 08/11/11 and the showed a service on an interview of supervisor on 10 quarterly fire ala are confusing and	HEALTH AND REHABILITATION TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) of the facility's Koorsen em Inspection and Testing y on 10/31/11 at 12:00 ly report showed a 7/27/11 on the first page the second page of the	3. WIN	STREET A	ARKS AVE	en ith kept n of ral che d. ential reas e Fire made	(X5) COMPLETION DATE
					will utilize the Interior Prever Maintenance Monitoring Too monthly times 3 months and Quarterly until compliance has been maintafor 2 consecutive quarters (\$\frac{3}{4}\tachment A). The audits will be reviewed	ntative bl then ained See	
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID: J	L9C21	Facility I	D: 000110 If continuation s	sheet Pa	ge 22 of 40

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 02	(X3) DATE S COMPL		
		155203	A. BUIL B. WING			10/31/20	
	OVIDER OR SUPPLIER	HEALTH AND REHABILITATION		STREET AI	DDRESS, CITY, STATE, ZIP CODE NRKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0052 SS=E i a a a a a a a a a a a a a a a a a a	A fire alarm system nstalled, tested, an accordance with N Code and NFPA 7 approved maintena complying with app NFPA 70 and 72. Based on observation facility failed to effice alarm boxes accorrect height. Not the National Fire states each manual fire less than 3 1/2 femore than 4 1	n required for life safety is and maintained in IFPA 70 National Electrical 2. The system has an ance and testing program plicable requirements of 9.6.1.4 ation and interview, the ensure 2 of 17 manual were mounted at the IFPA 72, 1999 Edition of Alarm Code at 2-8.1 al fire alarm box shall be d. The operable part of alarm box shall be not et (42 inches) and not eet (54 inches) and not eet (54 inches) above deficient practice could tely 25 residents who oorth Hall, and any he first floor beauty shop, all.	K0	0052	the facilities quality assurance meeting and issues will be addressed and the abplan will be altered according needed. 5. The above plan of correction will be completed on or before November 30, 2011. K 052 Requires that a facility A fire alarm system required life safety is installed, tested, maintained in accordance with NFPA 70 National Electrical and NFPA 72. The system has approved maintenance and testing program complying we applicable requirements of N 70 and 72. 9.6.1.4 The facility ensure this requirement is meet through the following: 1. No residents were harmed. Fire alarm boxes identified as a concern were lowered which include, the Service Hall pull station near beauty shop and 2 West Hall pull station (note 2567 as 2 North Hall). 2. All residents have the potential that affected. Facility inspected and further areas of concern noted. 3. Maintenance staff in-serviced on K052. 4. The above plan of correction will be completed on or before November 30, 2011.	ove ly, if on e has: for and th Code as an ith FPA y will et	11/30/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203			A. BUIL	DING	02	(X3) DATE : COMPL 10/31/2	ETED
HILLCRE		HEALTH AND REHABILITATION	B. WINC	STREET AI 203 SPA JEFFER	DDRESS, CITY, STATE, ZIP CODE NRKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
K0054 SS=C	floor Service Hall box was mounted and the second fl station box was rethe floor. This we maintenance suppart the time of observing door hold approved, maintain accordance with the specifications. So the sure 1 of 73 was not located could prevent the detector. LSC so functions of a functions of a functions of a functions of a function of the deficient practice.	e detectors, including those d-open devices, are ned, inspected and tested in ne manufacturer's 0.6.1.3 eservation and acility failed to smoke detectors d where airflow he operation of the 0.6.1.3 says the 0.6.1.3 says the estatement of the operation of the ope	K0	054	K054 Requires that a facility All required smoke detectors including those activating dochold-open devices, are appromaintained, inspected and te in accordance with the manufacturer's specifications 9.6.1.3 The facility will ensure requirement is met through the following: 1. No residents we harmed. Koorseen Fire and Security moved the First Flock Service Hall smoke detector identified as a concern (See Attachment F). Additionally, and #17 smoke detectors we repaired (See Attachment F). All residents have the potentiable affected. No further concentred. 3. Maintenance staff in-serviced on K054. 4. The Administrator or designee will utilize the Interior Preventative.	por poved, sted a. e this ne re or # 16 re . 2. fall to erns	11/30/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JL9C21

Facility ID:

000110 If continuation sheet

Page 24 of 40

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2	2) MULTIPLE CO			(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. I	BUILDING	02		COMPL	
		155203	В. V	WING			10/31/2	UII
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STAT	E, ZIP CODE		
HILLODE	ST CENTRE FOR	HEALTH AND REHABILITA	MOITA		ARKS AVE RSONVILLE, IN47	130		
			T		CONVILLE, IN47	100		OLE.
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULI	r	ID PREFIX	PROVIDER'S PLA (EACH CORRECTIVE A	N OF CORRECTION ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED DEFICI	TO THE APPROPRIAT	E	DATE
	Findings includ				Maintenance M	Ionitoring Tool		
	i manigs merae				monthly times			
	Based on obse	rvation on			Quarterly until of the been maintained		IS	
		:20 a.m. with the			consecutive qu			
	maintenance s				Attachment A).	•	ll be	
	administrator,	•			reviewed during	-	_	
	•	oke detector near			quality assuran issues will be a			
		I room corridor was			above plan will		uic	
		ot from a return air			accordingly, if r	needed. 5. The		
		s verified by the			above plan of o		ре	
	maintenance s	•			completed on on November 30,			
	administrator a	•			NOVEITIDEL 30,	۷۱۱.		
	observation.	at the time of						
	observation.							
	3.1-19(b)							
		ord review and interview,						
	1	d to ensure 2 of 73 smoke						
		for sensitivity were either						
		llibrated or replaced. LSC						
		provisions of 9.6 cover						
		ons of the fire alarm						
	1 -	g fire detection systems.						
		ers to NFPA 72, The						
		arm Code. NFPA 72, at						
	_	sting in accordance with						
	-	ting Frequencies. Table						
	()	s to 7-3.2.1 which						
	-	r sensitivity shall be						
		l year after installation						
	and every alternate year thereafter. After							
	the second required calibration test, if							
	sensitivity tests indicate the detector had							
	remained within	its listed and marked						
FORM CMS-2	2567(02-99) Previous Versi	ons Obsolete Event II	: JL9C	21 Facility I	D: 000110	If continuation sh	neet Par	ge 25 of 40

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CO LDING	NSTRUCTION 02	(X3) DATE : COMPL	
		155203	B. WIN			10/31/2	011
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
					ARKS AVE		
		HEALTH AND REHABILITATION	•	<u>. </u>	RSONVILLE, IN47130		
(X4) ID PREFIX		FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	sensitivity range,	the length of time					
	between calibrati	•					
	permitted to be e	xtended to a maximum					
	_	frequency is extended,					
	records of detect	or caused nuisance					
	alarms and subse	equent trends of these					
	alarms shall be m	naintained. In zones or in					
	areas where nuis	ance alarms show any					
	increase over the	•					
		shall be performed. To					
		ctor is within its listed					
		itivity range, it shall be					
	1	of the following methods:					
	(1) Calibrated te						
		r's calibrated sensitivity					
	test instrument						
		ol equipment arranged for					
	the purpose						
	(4) Smoke detec						
	_	ereby the detector causes					
	_	ntrol unit where its					
	1	side its listed sensitivity					
	range (5) Other calibra	ated sensitivity test					
	` ′	ed by the authority having					
	jurisdiction	d by the authority having					
	Detectors found	to have a sensitivity					
	outside the listed	and marked sensitivity					
	range shall be cle	eaned and recalibrated or					
	be replaced.						
	The detector sensitivity shall not be tested						
	or measured using any device that						
		nmeasured concentration					
	of smoke or othe	r aerosol into the					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING	02	COMPL	ETED
		155203	B. WIN			10/31/2	011
			B. WIIV		DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8		1	ARKS AVE		
HILLCRE	ST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	detector.						
	This deficient pr	actice affects all residents					
	in the facility.						
	,,						
	Findings include	:					
	Based on a revie	w of Koorsen Fire Alarm					
	System Inspection	on and Testing Reports					
	Quarterly on 10/	31/11 at 12:00 p.m., the					
	quarterly report	dated 01/26/10 showed					
	the # 16 smoke of	letector located by the					
		om and the # 17 smoke					
	_	at the nurses' station both					
		testing. Based on a					
	_	oorts provided by the					
	_	ted 01/26/10, 04/12/10,					
	•	11 and 08/11/11, there					
		provided the two failed					
		were replaced. This was					
	_	naintenance supervisor					
	and administrato	or at the time of record					
	review.						
	3.1-19(b)						
TT00/2	Demoined	ia amindan ayata					
K0062		tic sprinkler systems are stained in reliable operating					
SS=F	-	inspected and tested					
		.7.6, 4.6.12, NFPA 13,					
	NFPA 25, 9.7.5	•					
	1. Based on obs	ervations and interview,	K	0062	K 062 Requires that a facility		11/30/2011
	the facility failed	to ensure 1 of 4 stairway			Required automatic sprinkler		
	_	3 rooms were provided			systems are continuously	ina	
		1			maintained in reliable operat	iiig	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION 02			(X3) DATE SURVEY COMPLETED	
This Team of Condition	155203	A. BUII			10/31/2011	
		B. WIN		DDDESS SITV STATE ZID CODE		
NAME OF PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE ARKS AVE		
HILLCREST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX (EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
with sprinkler he	eads free of paint. 9.7.5			condition and are inspected		
refers to NFPA 2	25, Standard for the			tested periodically. 19.7.6, 4		
Inspection, Testi	ng, and Maintenance of			NFPA 13, NFPA 25, 9.7.5 Th	ne	
_	e Protection Systems.			facility will ensure this requirement is met through t	he	
	1 requires sprinklers to be			following: 1. No residents we		
•	• •			harmed. Sprinklers identified		
	, foreign materials, paint,			a concern have been correct		
	nage and shall be installed			2. Paint was removed from		
	entation (upright,			second floor 2 East exit stair	•	
•	vall). Any sprinkler shall			and the soiled linen room ac		
be replaced that	is painted, corroded,			from the 2 East stairway. All other sprinkler heads were		
damaged, loaded	l, or in the improper			inspected for paint and no		
orientation. This	deficient practice could affect			concerns noted. 3. Reserve		
12 residents who re	side on the second floor 400			stock of 6 sprinkler heads		
Hall and would use	the 2 East stairway during an			obtained . 4. Zip strip ties w		
evacuation.				removed from sprinklers in the	ne	
				Central Supply Room and		
Findings include:				hangers on existing pipe wer removed and corrected. 5. A		
Rosed on observation	on on 10/31/11 at 11:10 a.m.			sprinkler gauges found in ne		
	ee supervisor and administrator,			replacement were replaced.		
	ast exit stairway had two			Attachment H). 6. The two	`	
	vith yellow paint, and the			sprinkler head escutcheons i	n the	
soiled linen room ac	cross the corridor from the 2			Beauty Shop identified as a		
	ne sprinkler covered with white			concern have been addresse		
	ified by the administrator and			and are flush to the ceiling. other escutcheons have bee		
maintenance superv	isor at the time of observation.			inspected and no other conc		
2.1.10(1)				noted. 7. The Sprinkler Sys		
3.1-19(b)				was inspected by Brown Spr		
2 Racad on about	ervation and interview,			and no other concerns noted		
				(See Attachment G). 8.		
<u> </u>	to ensure a stock of at			Maintenance staff was in-ser on K062. 9. The Administrate		
• •	nklers were stored in a			designee will utilize the Inter		
•	cabinet on the premises for replacement			Preventative Maintenance		
2 2	101 Section 9.7.5 refers			Monitoring Tool monthly time	es 3	
to NFPA 25, Sta	to NFPA 25, Standard for the Inspection,			months and then Quarterly u	ntil	
Testing, and Ma	intenance of Water-Based			compliance has been mainta		
				for 2 consecutive quarters (S	see	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155203	B. WIN			10/31/2	011
			D. W.I.		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			ARKS AVE		
HILLCRE	EST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Fire Protection Systems. NFPA 25,				Attachment A). The audits w		
	2-4.1.4 requires a supply of at least six		reviewed during the facilities				
	spare sprinklers	shall be stored in a			quality assurance meeting a issues will be addressed and		
		remises for replacement			above plan will be altered		
	_	ock of spare sprinklers			accordingly, if needed. 10. T	he	
		onally representative of			above plan of correction will		
		nperature ratings of the			completed on or before		
					November 30, 2011.		
		s. A minimum of two					
	•	h type and temperature					
	_	hall be provided. The					
	cabinet shall be	so located so it will not be					
	exposed to mois	ture, dust, corrosion, or a					
	temperature exce	eeding 100 degrees F (38					
	degrees C). This	deficient practice affects all					
	residents in the faci	-					
	Findings include:						
	<i>S</i>						
	Based on observation	on on 10/31/11 at 10:45 a.m.					
		ce supervisor and administrator,					
		tler riser room lacked a cabinet					
		are sprinklers. This was					
		ntenance supervisor and					
	auministrator at the	time of observation.					
	3.1-19(b)						
		ervation and interview,					
	the facility failed	l to ensure a complete					
	automatic sprink	eler system was installed					
	_	accordance with NFPA 13, 1999					
		Installation of Sprinkler					
		13, 6-1.1.5 requires					
	1 -	or hangers shall not be					
		nonsystem components.					
	i his deficient pr	actice could affect any					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	ONSTRUCTION	COMPI		
AND FLAN	OF CORRECTION	155203	A. BUI	LDING	02	10/31/2	
		133203	B. WIN			10/31/2	.011
NAME OF I	PROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP CODE		
	ST CENTRE EOR	HEALTH AND REHABILITATION			ARKS AVE RSONVILLE, IN47130		
					NOONVILLE, IN47 130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	7	(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION DATE
TAG		·	+	IAG			DATE
	_	ne Administration Hall					
	near the central s	suppry room.					
	Findings include	:					
	Based on observa	ation on 10/31/11 at					
	11:50 a.m. with t	the maintenance					
	supervisor and a	dministrator, the					
	Administration I	Hall central supply room					
	had a new two in	ch sprinkler pipe which					
	ran along the eas	t wall to the bathroom					
	with four sprinkl	er pipe hangers attached					
	to the original sp	rinkler pipe supplying					
	sprinkler coverag	ge in the east side of the					
	central supply ro	om. Furthermore, the					
	west side of the	central supply room had a					
	two inch sprinkle	er pipe with zip strip ties					
	used to tie down	telephone lines along the					
	twenty foot lengt	th of sprinkler pipe. This					
	was verified by t	he maintenance					
	supervisor and a	dministrator at the time of					
	observation.						
	3.1-19(b)						
		ervation, record review					
		e facility failed to ensure					
	_	ystems was continuously					
		iable operating condition					
	_	d tested periodically.					
	NFPA 25, 2-3.2	requires gauges shall be					
	replaced every 5	years or tested every 5					
	years by compar	ison with a calibrated					
	gauge. Gauges r	not accurate to within 3					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 02	(X3) DATE (COMPL 10/31/20	ETED
NAME OF PROVIDER OR SUPPLIES			STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE	l	
	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
percent of the furecalibrated or repractice affects a facility including residents. Findings include Based on observe maintenance suppon 10/31/11 at 9 system riser local alarm system roof gauges without a gauges were maintenance of Brown Quarterly Inspection 10/31/11 at 12 indication the form pressure gauges replaced over the was verified by the supervisor and a p.m. review of the street o	Il scale shall be eplaced. This deficient all occupants in the gration with the ervisor and administrator and all four pressure and administrator and after pressure and administrator and after an and sprinkler system and approximately approximately and a sprinkler system and a sprinkler system and a sprinkler system are sprinkler system are recalibrated or a past eight years. This			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE TE	
3.1-19(b)						
the facility failed sprinkler heads i	ervation and interview, I to ensure 2 of over 300 In the facility were Is deficient practice could					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		(X2) MULTIPLE C A. BUILDING	ONSTRUCTION 02	(X3) DATE SURVEY COMPLETED 10/31/2011	
	PROVIDER OR SUPPLIER	HEALTH AND REHABILITATION	203 S	ADDRESS, CITY, STATE, ZIP CODE PARKS AVE ERSONVILLE, IN47130	
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	affect any resider Service Hall beau	nts who use the first floor uty shop.			
K0064 SS=E	a.m. with the main administrator, the escutcheons in the flush to the ceiling three inch gap into the drop ceiling and acknowledged by supervisor and accordance observation. 3.1-19(b) Portable fire extingulated to extinguishers of accordance of the extinguishers of the top of portable weighing 40 pour	ation on 10/31/11 at 9:40 intenance supervisor and e two sprinkler head he beauty shop were not ag leaving a one inch to to the attic space above assembly. This was the maintenance diministrator at the time of spuishers are provided in all ancies in accordance with 6, NFPA 10 ation and interview, the ensure 1 of 18 portable is was installed correctly. Andard for Portable Fire thapter 1, 1-6.10 requires the fire extinguishers ands or less should be no	K0064	K 064 Requires that a facility Portable fire extinguishers at provided in all health care occupancies in accordance v 9.7.4.1. 19.3.5.6, NFPA 10 T facility will ensure this requirement is met through t following: 1. No residents we harmed. The fire extinguisher	with The he
	more than five fe floor and those w pounds should be one half feet (42	et (60 inches) above the reighing more than 40 e not more than three and inches) above the floor.		harmed. The fire extinguished located in the first floor loung identified as a concern was lowered. 2. All residents hav potential to be affected. All of fire extinguishers were insperand no further problems note.	ge e the other ected

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 02 A. BUILDING 155203 10/31/2011 WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 SPARKS AVE HILLCREST CENTRE FOR HEALTH AND REHABILITATION JEFFERSONVILLE, IN47130 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5)PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE Maintenance staff in-serviced on residents using the first floor lounge. K064. 4. The Administrator or designee will utilize the Interior Findings include: Preventative Maintenance Monitoring Tool monthly times 3 months and then Quarterly until Based on observation on 10/31/11 at compliance has been maintained 10:10 a.m. with the maintenance for 2 consecutive quarters (See supervisor and administrator, the first Attachment A). The audits will be floor lounge fire extinguisher measured reviewed during the facilities sixty six inches from the top of the quality assurance meeting and issues will be addressed and the extinguisher to the floor. This was above plan will be altered verified by the maintenance supervisor accordingly, if needed. 5. The and administrator at the time of above plan of correction will be observation. completed on or before November 30, 2011. 3.1-19(b) OTHER LSC DEFICIENCY NOT ON 2786 K0130 SS=E K0130 K 130 Requires that a facility: 11/30/2011 Based on observation, interview and MISCELLANEOUS OTHER LSC record review; the facility failed to ensure DEFICIENCY NOT ON 2786 The the care and maintenance of 1 of 1 rolling facility will ensure this fire doors was in accordance with NFPA requirement is met through the following: 1. No residents were 80. LSC 4.5.7 requires any device, harmed. Rolling fire door will be equipment or system which is required for inspected on or before November compliance with the provisions of this 30 th . 2011. 2. All residents Code, such device, equipment or system have the potential to be affected. shall thereafter be maintained unless the No other concerns noted. 3. Maintenance staff in-serviced on Code exempts such maintenance. NFPA K130. 4. The Rolling Fire Door 80, 1999 Edition, the Standard for Fire was added to the facility Doors and Fire Windows, Section Preventative Maintenance 15-2.4.3 requires all horizontal or vertical Program (See Attachment I). 5. The Administrator or designee will sliding and rolling fire doors to be utilize the Interior Preventative inspected and tested annually to check for Maintenance Monitoring Tool proper operation and full closure. monthly times 3 months and then

000110

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	02	COMPL	ETED
		155203	B. WING			10/31/2	011
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER				ARKS AVE		
	ST CENTRE FOR	HEALTH AND REHABILITATION			RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	•	release mechanism shall			Quarterly until compliance have been maintained for 2	as	
	be done in accord				consecutive quarters (See		
		structions. A written			Attachment A). The audits wi	ill be	
	record shall be m	naintained and shall be			reviewed during the facilities		
	made available to	o the authority having			quality assurance meeting ar		
	jurisdiction. Thi	s deficient practice could			issues will be addressed and	the	
	affect any residen	nts who use the main			above plan will be altered accordingly, if needed. 6. The	e	
	dining room, loca	ated adjacent to the			above plan of correction will		
	kitchen.				completed on or before		
					November 30, 2011.		
	Findings include	:					
	S						
	Based on observa	ation on 10/31/11 at 9:50					
	a.m. with the ma	intenance supervisor and					
	administrator, the	ere was a rolling fire door					
	protecting the op	ening from the kitchen to					
		room without an attached					
	_	Based on interview on					
		esequent Fire Safety					
		12:45 p.m. with the					
		ervisor and administrator,					
	-	lged there was no					
		nentation of an annual					
		t to check for proper					
	•	* *					
	•	Il closure of the vertical					
	_	located in the kitchen					
	opening to the m	an uning room.					
	3.1-19(b)						
K0144 SS=F		spected weekly and bad for 30 minutes per nce with NFPA 99.					

Facility ID:

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		A. BUII	LDING	02	(X3) DATE COMPL 10/31/2	ETED	
AND PLAN	PROVIDER OR SUPPLIES SUMMARY S (EACH DEFICIEN REGULATORY OR 1. Based on rece the facility failed record of weekly generator was m weeks. Chapter requires storage connection with systems shall be not more than 7	HEALTH AND REHABILITATION TATEMENT OF DEFICIENCIES (CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ord review and interview, It to ensure a written v inspections for the aintained for 24 of 52 3-4.4.1.3 of NFPA 99	A. BUII	LDING G STREET A 203 SP/	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY) K 144 Requires that a facility Generators are inspected we and exercised under load for minutes per month in accord with NFPA 99. 3.4.4.1. The will ensure this requirement met through the following: 1 residents were harmed. Generator testing completed Attachment J).2. All resident have the potential to be affernoother.	COMPL 10/31/2	ETED
	manufacturer's s batteries shall be immediately upor Furthermore, NF checking storage electrolyte levels than 7 days. 6-4 Level 2 EPSS, in components, sha and shall be exert at a minimum. 0 99 requires a wr performance, ext repairs for the ge maintained and a having jurisdicti practice could af and visitors. Findings include Based on record maintenance sup	pecifications. Defective repaired or replaced on discovery of defects. FPA 110, 6-3.6 requires batteries, including s, at intervals of not more at requires Level 1 and reluding all appurtenant appurtenant ll be inspected weekly reised under load monthly Chapter 3-5.4.2 of NFPA atten record of inspection, recising period, and renerator to be regularly revailable by the authority on. This deficient affect all residents, staff			current Preventative Mainter Program for the Emergency Generator was reviewed with changes (See Attachment K Maintenance staff in-service K144. 5. The Administrator of designee will utilize the Inter Preventative Maintenance Monitoring Tool monthly time months and then Quarterly compliance has been maintator 2 consecutive quarters (S Attachment A). The audits wereviewed during the facilities quality assurance meeting a issues will be addressed and above plan will be altered accordingly, if needed. 6. The above plan of correction will completed on or before November 30, 2011.	th no). 4. d on or ior es 3 intil ained See ill be ind d the	

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	LDING	NSTRUCTION 02	(X3) DATE COMPL 10/31/2	ETED
	PROVIDER OR SUPPLIER	HEALTH AND REHABILITATION	 STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	weekly inspection the months of Oc 2010, December 2011, and Septer based on intervier review, the admino other docume review to verify inspections were 3.1-19(b) 2. Based on recofor 6 of 12 month exercise the generative for Emergency at Systems, chapter Standard for Hean Nursing Home reessential electrical conform to Type Chapter 3 of NFI of NFPA 99 requirements of NFPA 99 requirements of NFPA 110. Chapter 3 of NFI of NFPA 110. Chapter 3 of NFI of NFPA 110. Chapter 3 of NFPA 1	rd review and interview, as the facility failed to				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155203		LDING	nstruction 02	(X3) DATE (COMPL 10/31/2	ETED	
NAME OF I	PROVIDER OR SUPPLIER			DDRESS, CITY, STATE, ZIP CODE		
				ARKS AVE		
		HEALTH AND REHABILITATION	JEFFER	RSONVILLE, IN47130		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
1710		n 30 percent of the EPS	1710			DITIE
	nameplate rating	_				
		naintains the minimum				
	exhaust gas temp					
	recommended by	y the manufacturer.				
	The date and tim	e of day for required				
	testing shall be d	lecided by the owner,				
	based on facility	•				
	•	actice could affect all				
	residents, staff a	nd visitors.				
	Findings include:					
		ew and review of the				
	Generator Testin					
	_	ervisor and administrator				
		2:30 p.m., there was no hly load test for the				
		er 2010, November 2010,				
		January 2011, July 2011,				
	· ·	011. Additionally,				
	•	ew during the record				
		nistrator stated there was				
	•	entation available for				
	review to verify	these monthly load tests				
	on the generator	were conducted.				
	2.1.10(1.)					
	3.1-19(b)					
	3. Based on obse	ervation and interview,				
	the facility failed	l to provide adequate				
		lighting in and around the				
	generator set in a	accordance with NFPA				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING B. WING			COMPLETED 10/31/2011		
	PROVIDER OR SUPPLIER	HEALTH AND REHABILITATION		STREET A	DDRESS, CITY, STATE, ZIP CODE ARKS AVE SONVILLE, IN47130		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE
	LSC Section 7.9. emergency gener emergency lightinstalled, tested, accordance with Emergency and SNFPA 110 Section EPS (Emergency equipment locating battery-powered deficient practice residents, staff and Findings include Based on observation and state of the basement of the basement of the basement of the basement of the emergency where the emergency housed lacked battery-power over where the emergency housed lacked battery-power over the emergency of the basement of the b	rators providing power to ng systems shall be and maintained in NFPA 110, Standard for Standby Power Systems. On 5-3.1 requires that the Power Supply) on shall be provided with emergency lighting. This e could affect all nd visitors. : ation with the ervisor and administrator 1:50 a.m., the emergency I outside and to the west west physical therapy d in a metal fence with a r the fencing. The area ency generator was attery backup lighting. I by the maintenance diministrator at the time of					
K0147 SS=E	Electrical wiring ar accordance with N Code. 9.1.2	nd equipment is in IFPA 70, National Electrical					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JL9C21

Facility ID: 000110

If continuation sheet

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE C	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	02	COMP	
		155203	B. WIN	G		10/31/2	2011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					PARKS AVE		
HILLCRE	ST CENTRE FOR	HEALTH AND REHABILITATION		JEFFE	RSONVILLE, IN47130		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		ation and interview, the	K()147	K 147 Requires that a facilit		11/30/2011
	I -	ensure extension cords			Electrical wiring and equipment in accordance with NFPA 79		
	including powers	strips and non-fused			National Electrical Code. 9.		
	multiplug adapte	ers were not used as a			The facility will ensure this		
	substitute for fix	ed wiring in 5 of 163			requirement is met through		
	rooms. LSC 19.	5.1 requires utilities to	1		following: 1. No residents w		
	comply with Sec	tion 9.1. LSC 9.1.1	1		harmed. All cords identified concern were removed. 2. A		
	requires electrica	al wiring and equipment			residents have the potential		
	•	NFPA 70, National			affected. No other concerns		
		1999 Edition. NFPA 70,			noted. 3. Maintenance in-se		
		quires that, unless			on K147. 4. Policy for exten		
		nitted, flexible cords and			cord and power strip usage		
		be used as a substitute for			reviewed with no changes n (See Attachment L). 5. Th		
		structure. This deficient			Administrator or designee w		
	_	fect any residents using			utilize the Interior Preventat		
	_				Maintenance Monitoring To		
		piratory therapy office,			monthly times 3 months and		
		office, any residents using			Quarterly until compliance has been maintained for 2	ias	
		auty shop, 2 residents			consecutive quarters (See		
		om 112, and 2 residents			Attachment A). The audits v	vill be	
	who reside in roo	om 315.			reviewed during the facilities		
	Findings include	:			quality assurance meeting a issues will be addressed an		
	-				above plan will be altered		
	Based on observ	ations on 10/31/11 during			accordingly, if needed. 6. The above plan of correction will		
		lity from 8:00 am to 1:10			completed on or before	. 50	
		intenance supervisor and			November 30, 2011.		
	_	e first floor respiratory					
		id payroll office each had					
	1 2	ge extension cord in use					
		outer and printer.					
		following rooms used					
		w electrical equipment					
	plugged in to po						
		wer strips, uty shop had a hair dryer					
	a. 1110 1110t 11001 bca	aty and a hall dryon					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

NAME OF PROVIDER OR SUPPLIER HILLCREST CENTRE FOR HEALTH AND REHABILITATION (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFEX (EACH DEFICIENCY MUST BE FERCEDED BY PLLL TAG REQUIATORY OR ISC DENTIFYING MPROPRIATION) Drugged in to a power strip. C. Resident room 15 fs had two refrigerator plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1-10 p.m. exit conference, the facility did not have a written policy for the use of power strips. 3.1-19(b)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155203	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ON	(X3) DATE SURVEY COMPLETED 10/31/2011	
HILLCREST CENTRE FOR HEALTH AND REHABILITATION (X4) ID (X4) ID (EACH DEFICIENCY MUST BE PERCEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY) DATE (X5) COMPLETION DATE (X5) COMPLETION DATE DEFICIENCY) A Gesident room 112 had a refrigerator plugged in to a power strip. C. Resident room 112 had a refrigerator splugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.					ET ADDRESS. C	CITY, STATE, ZIP CODE		
HILLCREST CENTRE FOR HEALTH AND REHABILITATION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Dlugged in to a power strip. b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 315 had two refrigerators plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.	NAME OF P	ROVIDER OR SUPPLIER						
PREFIX TAG (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Plugged in to a power strip. b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 112 had a refrigerators plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.				JEFFERSONVILLE, IN47130				
Plugged in to a power strip. b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 112 had a refrigerators plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.					PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		N · ·	
plugged in to a power strip. b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 112 had a refrigerator plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.							ΓE	
b. The first floor respiratory therapy office had a refrigerator plugged in to a power strip. c. Resident room 112 had a refrigerator plugged in to a power strip. d. Resident room 315 had two refrigerators plugged in to a power strip. Based on an interview with the maintenance supervisor and administrator on 10/31/11 at the 1:10 p.m. exit conference, the facility did not have a written policy for the use of power strips.	TAG			IAG		DEFICIENCE		DATE
		b. The first floor resprefrigerator plugged in c. Resident room 11: a power strip. d. Resident room 31 in to a power strip. Based on an intermaintenance sup on 10/31/11 at the conference, the five written policy for	oiratory therapy office had a n to a power strip. 2 had a refrigerator plugged in to 5 had two refrigerators plugged rview with the ervisor and administrator are 1:10 p.m. exit accility did not have a					